Kentucky Division of Developmental and Intellectual Disabilities

CMHC Crisis Coordinator Manual

FY-2021

TABLE OF CONTENTS

Section 1: Overview

A crisis is defined as a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

Crisis services are designed to be time-limited in nature and are not meant to replace community services. Individuals who have co-occurring behavioral health, I/DD and/or substance use diagnoses shall be evaluated for and have access to all crisis services related to their needs. Crisis services are available 24 hours a day, 7 days a week, and 365 days a year.

Individuals in crisis are defined as being at risk of losing the support they need to remain in the community due to:

a.--The individual is experiencing a behavioral or psychiatric emergency;

b.--The individual or family is experiencing an acute crisis as determined by the *Institute on Complex Disabilities Crisis Triage Codes* rating scale (as specified by the Department);

c.--It is determined that the individual has a history of multiple crisis episodes; or

d.--The individual is at a substantial risk of future crisis and preventive efforts are needed, and

e.--Exhausting other supports prior to referral, these supports are extraordinary in nature.

Community Mental Health Centers are allocated state general funds to provide services to individuals within their region who have intellectual or other developmental disabilities. Individuals of all ages are eligible to receive crisis services. Availability of crisis funding for services may vary according to the individual's eligibility to access other funding sources (such as insurance, waivers, etc.) for that service. Immediate supports may be provided to maintain health and safety in emergency situations when there is reasonable evidence to support that the individual has I/DD. Eligibility review to validate reported I/DD diagnosis and verify support needs shall be completed without delay. Eligibility review shall occur prior to implementing non-critical services.

Definitions

Crisis service plan-a person-centered and specific plan of action to implement recommendations made by the individual and their team to prevent and manage possible future crises. The recommendations and resulting plan of action should be based on the needs identified during the debriefing process. Each task on the plan should clearly identify what action will be taken, who will be responsible for completing the task, the target for completion of the task, and when the task is completed. The service plan is a living document and can be adjusted and modified as needed.

Crisis/emergency response plan-a plan for individuals who have experienced a crisis episode and there is a risk of recurrence. The plan is developed with the individual and their team to identify early warning signs of a crisis episode and previously successful de-escalation or intervention strategies that caregivers can use including, who should provide the intervention, when to use the intervention, for how long, how often, etc. The plan should also clearly identify the circumstances under which the individual requires emergency intervention and how to access those services. Any restrictions on access to items that is not voluntary by the individual may require approval of a rights restriction through the Human Rights Committee (HRC).

Safety plan-a plan to prevent self-injurious behavior (SIB) for an individual identified as being at risk. The plan is developed by the individual and a mental health professional specific to their strengths, resources, and needs. It may include coping strategies that are implemented to prevent/reduce symptoms, warning signs or triggers for SIB, and an action plan for the individual and their caregivers to implement if symptoms become unmanageable. It should include contact information for the individual's behavioral health provider, as well as other emergency contacts and any items that the individual should not have in the home or otherwise have access to (or supervised access only). Any restrictions on access to items that is not voluntary by the individual may require approval of a rights restriction through HRC.

Debriefing-a process that occurs after safety of the individual is no longer a concern and calm has been returned following a crisis event. The individual and their team will meet to identify what may have contributed to or caused the crisis, and which interventions used were effective or ineffective. The team will make recommendations regarding preventing and managing possible future crises resulting in a plan of action (crisis service plan).

Triage-process of assigning a priority level to determine the urgency and type of response required to a crisis situation. I/DD crisis events are triaged using the *Institute on Complex Disabilities Crisis Triage Codes.*

Face to Face-occurring in person, in the same location, and not through an electronic method (telehealth, or phone) 907 KAR 3:170

Indirect/collateral contact- An indirect/collateral contact is contact with a service provider, natural support, community resource, guardian, etc. on behalf of the individual in crisis to obtain information or refer for additional supports or resources to help mitigate or prevent future crisis episodes.

Involuntary Admission Act for Individuals with Intellectual Disability/ KRS 202b-statute which outlines Kentucky requirements for involuntary admission to state owned ICF/IID facilities.

Involuntary Admission Act for Individuals with Mental Illness/KRS 202a-statute which outlines Kentucky requirements for involuntary admission for psychiatric hospitalization.

Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID)- These programs are designed to provide comprehensive and individualized health care, training and habilitation services to individuals to promote their functional skills and independence. Kentucky has four state owned ICF/IID facilities (Oakwood, Hazelwood, Bingham Gardens and Outwood). Admission to these facilities requires a court order through KRS 202b process.

ICF Specialty clinic-Clinic on the grounds of state owned ICF/IID facility that provides a variety of specialized medical services to individuals with I/DD. Specialty clinic staff are experienced in treating persons with I/DD. These clinics allow individuals who live in community settings to have access to the same specialized care that individuals receive in our ICF/IID facilities.

Qualified ID crisis responder- Crisis responders are groups of dedicated staff who perform this role as one of their job duties for the entire region or assigned region and may work on a rotating basis.

- Shall be knowledgeable of crisis services and procedures, and the full array of supports available.
- Shall have the ability to access information and set up immediate supports, referrals, provide technical assistance, etc.
- Shall complete all required trainings for crisis staff, have in depth knowledge of and ability to work with the I/DD population

DDID Crisis Service Definitions

- **Crisis Respite:** Care provided to a participant, in a variety of settings, who is unable to independently administer self-care and is experiencing a highly unstable situation or temporary circumstance resulting in loss of supports that creates an immediate threat to health and safety. Individuals receiving crisis respite should have a clearly identified need for direct care that cannot be addressed through other available supports. Crisis respite may be provided for a limited amount of time in order to assess, identify, and implement appropriate supports. A plan for transition to alternative supports should be implemented as soon as needs can be assessed and resources identified. Individuals without a caregiver who are in need of ongoing residential supports should be transitioned to residential services without delay. Crisis respite is not intended to be utilized for individuals solely in need of housing.

- **Debriefing:** Analysis of the situation, subsequent to assistance by the regional ID crisis team for managing a crisis. Used for identifying things such as: what is known about the crisis, was the crisis plan or participant summary followed, if not why? Does the plan address the issue, have staff been adequately trained; what were the triggers, antecedents, environmental factors, de-stabilizing factors present? Are further assessments needed, have medications been recently changed or improperly administered; are there other issues to address? Also included should be subsequent recommendations, and intensive planning to help prevent further incidents/crises. Debriefing may consist of multiple meetings to resolve an issue and should be conducted at all triage levels. An action plan should be developed to include responsible parties and dates to complete tasks and may include periodic assessment of progress and training of staff to implement behavioral strategies and environmental changes.

- **Environmental Assessments:** Field-based assessments of the environment to determine what environmental factors may contribute to the occurrence or recurrence of a crisis. May include: physical/biological factors, physical surroundings, social practices and knowledge, technological adaptations and physical arrangements, culture, people and institutions with whom they interact, and other living (i.e. pets) and/or non-living things. Also consider how environmental factors are impacted by the crisis situation to identify potential risks to a participant's health, livelihood and safety.

- **Functional Assessment:** An assessment performed using evidenced based tools, direct observation, and empirical measurement to obtain and identify functional relationship between behavioral and environmental factors.

- **Mobile Crisis:** Mobile response which shall be provided, minimally for those with a Triage level 3 or 4, is available 24 hours a day, 7 days per week, 365 days a year to provide immediate services and technical assistance, and is to be performed where the person is located. The responder shall have access to needed behavioral, medical and psychiatric consultation, evaluation, and services. The response is provided by trained staff which may include the Intensive Case Manager.

- **Person Centered Planning:** At critical moments, when community living may be threatened, it may be necessary to assist and guide an individual in crisis and their person centered team in the identification of how strengths, capacities, desires, choices, and opportunities can be best utilized in defining and pursuing a meaningful life. Person Centered Planning (PCP) helps to assess and mitigate risk while determining what is important to and for the participant. It considers options available through Medicaid state plan, Medicaid Waiver programs, the Office of Vocational Rehabilitation, natural supports, and other resources. It maximizes community inclusion and generates action steps that can be taken immediately toward building a better life. Family, Guardian, if applicable, friends, and care service professionals are included in planning, as designated by the participant. PCP ensures services are delivered in a respectful manner and plans include insight into how to assess the quality of services being provided.

- **Technical Assistance/Resource Linkage:** A time-limited service in which participants are referred or linked to needed community information, resources, programs/services, and/or other supports, including specific information on how to apply for any applicable programs, health benefits, grants, or Medicaid waiver programs.

- **Medical Care/Prevention Services:** The goal of prevention is to prevent the onset of disease and/or to mitigate the effects once diagnosed. This includes services such as medical evaluations/screening tests for issues such as depression, alcohol or drug abuse, health conditions such as diabetes, obesity, or STDs; but can also be health monitoring, counseling and education, exams, injections, bloodwork, and other lab tests and screening. The supports are designed to address medical or related conditions that are interfering with the individual's stability in the community. They are intended to ultimately provide relief to the individual being supported and to provide additional information in the identification of the nature of supports needed.

- **Transportation** is provided in order to gain access to integrated community services, activities, resources, and organizations typically utilized by the general population. This is only provided when transportation is not otherwise available through natural supports or a Medicaid program.

Section 2: Referral, Triage, and Initial Response

All CMHCs are required to operate a behavioral health crisis line 24 hours a day, 7 days a week to allow individuals within their region to access crisis services. Crisis line staff shall identify individuals with an intellectual or developmental disability and provide referral to I/DD crisis team in addition to providing any other identified behavioral health crisis services.

Individuals may also be referred from other points of entry in the crisis service system, such as through involuntary psychiatric hospitalization evaluations (KRS 202a), evaluation at a crisis stabilization unit (CSU), emergency room visits, etc. The CMHC must ensure that staff at ALL various points of entry are trained on the procedure to refer individuals identified as I/DD to the designated on-call qualified I/DD crisis responder within 15 minutes.

The on-call qualified I/DD crisis responder must be available to receive the initial referral, triage the situation, and provide immediate response based on the appropriate triage level. Crisis situations are triaged using the Institute on Complex Disabilities Crisis Triage Codes. Crisis situations that are triaged at a 3 or 4 require an immediate, in person mobile response by the on call crisis responder. Crisis events that triage a 1 or 2 may include immediate assistance in person or by phone in addition to an in person follow up/debriefing..


Institute on Complex Disabilities

The goal of the initial crisis response is to collect additional information on the nature of the crisis, connect individuals to resources, or provide other interventions to provide for immediate stabilization of the situation in the least restrictive setting that will ensure health and safety.

If the crisis responder has concerns that the individual may be experiencing a behavioral health emergency, they should collaborate with their behavioral health crisis team to identify the appropriate response including, as a last resort, a petition for involuntary psychiatric hospitalization (KRS 202A).


202a presentation.pdf

Crisis Contact Data Sheets (CCDS)

The Crisis Contact Data Sheet (CCDS) documents all elements of the initial crisis referral and response. It includes demographic information, diagnoses, a summary of the initial referral, triage code assigned, a summary of response to the situation and outcomes. CCDS allows the Division of Intellectual and Developmental Disabilities (DDID) to monitor the provision of crisis services in accordance with contract requirements as well as identifying trends across the state.

CCDSs are completed when any crisis services are initiated in response to a new request for assistance. A CCDS shall be completed for each unique situation where crisis services are requested. If the crisis team receives multiple calls due to the individual having multiple crisis incidents, each unique situation must be triaged on a separate CCDS to document the situation and response, including a debriefing for each incident.

CCDSs are completed via a database maintained by DBHDID. In order to access the database you must request access to the system by submitting the attached form.

Request for Logon Access.docx

Once your access is approved, you will receive an email with your login and instructions for accessing the system and entering records. If you experience technical problems with the CCDS database or have questions about how to complete a CCDS please notify your regional liaison. The Crisis Contact Data Sheet can be created any time after a crisis event and can be saved until all the information has been added. The CCDS Easy reference sheet provides instruction on how to complete each section of the form.

Crisis Contact Data Sheet 2020.pdf

CCDS tip sheet 2020.pdf

Once all the information has been entered and the debriefing sheet uploaded, you can submit the form. All CCDSs must be entered into the system and submitted for approval on or before the 25th of the following month of the crisis event (ex. January CCDS must be submitted by February 25th). Once you submit the CCDS you can no longer make any changes. CCDSs are reviewed monthly by the DDID regional liaison. Crisis sheets that meet all contract requirements will be approved and you will be notified by a system-generated email. If additional information or corrections are needed, you will receive an email notification that the sheet has been rejected with comments on what is needed. This sheet may be resubmitted (only one resubmission is allowed) within 10 business days for review. Crisis sheets in which contract requirements are not met (ex. incident wasn't properly triaged, client was not connected to I/DD crisis staff within 15 minutes of call, etc.); or rejected sheets that are not resubmitted timely will be closed and cannot be resubmitted.

Section 3: Debriefing

Debriefing is the analysis of a situation and subsequent recommendations including intensive planning to help prevent further incidents/crises. The CMHC crisis team is responsible for planning and facilitating the debriefing meeting(s). The debriefing process begins after the initial crisis response and any immediate health and safety issues have been addressed. All crisis incidents regardless of triage level, require a debriefing meeting. If the individual/guardian refuses to participate or cannot be located following the initial response in order to schedule the meeting, then this must be clearly documented with specific information regarding attempts made to contact the individual or reason for refusal.

If subsequent crisis events occur prior to the debriefing meeting for the first incident, the incidents may be debriefed together if the relevant parties for both incidents can attend the meeting. In these situations, both incidents are analyzed and addressed within the debriefing document. The debriefing document must indicate that it is addressing both events and be attached to both crisis contact data sheets when submitted. If a new crisis event occurs AFTER a debriefing has been completed for a previous event, a new debriefing meeting is required in order to review the previous crisis plan and make any needed adjustments to the plan based on the additional data obtained during the new event.

First step in debriefing is to begin gathering information about the individual and their situation. This information gathering should include the people involved in their lives (both paid and unpaid); if in a waiver, a copy of the participant summary; if receiving behavior supports, a copy of the behavior plan. Once these documents have been gathered, schedule the debriefing meeting. The people that should be invited to the meeting include: team members related to any current supports and services (MPW, SCL, HCB, SGF, behavioral health, etc.), the guardian (if applicable), any natural supports involved in the individual's life, any other agency personnel that is relevant to the crisis call (APS, hospital staff, police officers etc.), and the individual. It is very important that all attempts to contact people to schedule the debriefing are documented.

If the individual does not wish to attend or a guardian requests that they not be present then it should be documented in the debriefing minutes the reason for their absence. If someone is not currently in services a meeting should still be held (this could be with the individual and/or their guardian) and could include possible future service providers or other agencies that became involved at the time of the crisis to determine what caused the crisis and what can be done to help prevent a future crisis.

Preferably all debriefing meeting participants will meet face to face, however if that isn't possible, a phone line to conference in should be offered to those that are not available in person. The debriefing shall be held within 7 days of the date of the crisis event. If that does not happen then a specific explanation must be provided regarding the delay. Debriefing meetings should not be delayed as a result of ID crisis staff schedules. The debriefing meeting also should not be delayed due to the hospitalization of the individual. A meeting can be held without the individual to help plan for discharge or the meeting can be held at the hospital so that the individual may participate.

The crisis team will ensure that minutes from the meeting are documented. The debriefing form created by DDID can be used, but is not required. If using an alternate format, all of the information identified on the DDID form must be addressed in the document. The debriefing minutes should include the name of the individual, date of the crisis incident, date of the debriefing meeting, and a listing of all

those in attendance and their role/relationship with the individual. This includes documentation of any key individuals who declined or were unable to participate and the reason.


DEBRIEFING MEETING.doc

A summary of the crisis situation shall be provided (specifically the incident(s) that triggered contact with the crisis team-what happened, where it happened, who was involved. Also include information on what was happening before, each person's perception of the incident, what they observed and their actions. It is important to be clear in the summary what each participant's actions were and the timeline of events.

The team should examine each step of the incident and look for possible causes for the crisis. Discussion should include the strengths of the individual, current supports, and whether any additional information needs to be gathered; triggers, antecedents and destablizating factors that were or are still present; what changes have occurred with the individual's behavior or their environment, relationships, and medical status.

Are additional assessments (environmental, psychological, medical, psychiatric, etc.) needed? Any current person centered service plan, behavior plan, crisis plan should be thoroughly reviewed. Some questions to ask include-Are plans person centered? Were these plans followed? If not, why? Has everyone been trained on the plan? Does it adequately address the person's issues? If not what changes are needed? You must clearly explain the reason that changes are or are not being recommended for each applicable plan. It also might be necessary to discuss any rights restrictions that might be needed to implement recommended strategies.

After thorough discussion of the event(s) and identification of contributing factors and identified needs, the team shall develop an action plan for what is going to be implemented to prevent a future crisis. Crisis staff will educate the individual and their team regarding additional resources available to assist individuals in crisis. Resources such as brochures for the ICF specialty clinics and assistance with completing referrals can be provided Information about Involuntary Admission to ICF/IID via KRS 202b process can be provided and the crisis team can help determine if all community options have been explored and exhausted and whether ICF admission may address the individual's needs


202B presentation.pptx


202b sample forms including final orde


Oakwood clinic.pdf


2020 Hazelwood brochure.pdf


Lee clinic brochure pg 1.pdf


Lee clinic brochure pg 2.pdf


ICF Specialty Clinic crisis referral form.p

A task list should be completed including information on who is going to complete the task, the date that it should be completed and the date that it was completed. The ID crisis staff should provide a copy of the debriefing minutes to the team members so that each person has documentation of the task they agreed to complete. In an appropriate time frame, but before the crisis sheet/debriefing minutes are due to be submitted to DDID, a follow-up with everyone in attendance at the meeting to ensure tasks have been completed and to see how the individual is doing. This information should be provided on the bottom of the debriefing document.

Follow-up meetings should be scheduled if any additional evaluations or assessments (medical or behavioral) need to be completed to obtain a clear picture of how to best address the individual's needs. The team shall review the results/recommendations from these evaluations and discuss any changes in the individual's situation since the prior meeting, progress toward completion of the action plan, success or failure of interventions, etc. The team can then adjust the action plan as needed to address any newly identified needs and ensure that all recommendations from evaluations and assessments are appropriately implemented. All follow ups, actions and meetings shall be documented in the client's record.

Section 4 – Additional Information and Closure

Complex crisis events

Some crisis consumers have a history of multiple crisis episodes. The individual may experience short periods of stability, in which it appears that the crisis issue(s) have been addressed, only for the issues to re-emerge or even continue to escalate despite attempts at intervention. These individuals may require a more comprehensive approach to obtain stability. Factors that may influence the complexity of a crisis situation may include: comorbid behavioral health issues or substance abuse issues, complex medical needs, or an unstable environment. Many individuals involved in repeated crisis also have significant trauma histories requiring specialized treatment and interventions.

As a result of the intensity and volume of crisis events these individuals experience, many additional community partners/systems in addition to I/DD providers may be involved with this individual prior to, during, or after crisis. These parties may not be typically considered part of that individual's team and involved in their day to day care, but are important to the crisis response/intervention process. These community partners may include law enforcement and other first responders, local hospital emergency rooms, state psychiatric hospital, psychiatrist, court representatives, etc. All of these parties/systems should be represented and included in the process of identifying a plan to address and prevent crisis for the individual.

The CMHC crisis team works with the individual and their team to identify all of the parties needed to participate in creating a cross-system crisis plan and coordinate meetings to create the plan. Prior to the meeting, they should collect as much information as possible about the person's current supports and responses to interventions, history of supports/treatment, diagnosis, funding sources for services (insurance, waivers), legal status, etc.

The team then all meets together to share information, discuss, and create the plan. Basic elements of the plan include a summary of how the individual communicates with others and how best for individuals to communicate with them. The plan may also include a behavioral snapshot, which includes concise descriptions of the individual's behavior using a green, yellow, red zone model at baseline (green zone would identify typical behaviors and how the individual responds when things are calm and going well; yellow zone would describe at risk behavior/escalation/disruption ; and red zone would describe behavior that exceeds typical support capacity/dangerous, harmful, and/or destructive actions , specific to the person served. The next element of the plan is the intervention plan. Interaction and intervention strategies are paired with the appropriate level of behavior. The specific agencies and individuals who are responsible for providing the interaction/intervention should also be determined and detailed plans for restoring safety if red-zone behavior is reached.

The team should meet weekly by phone to discuss progress for the first 4 weeks following plan implementation. The CMHC crisis team will continue to monitor and organize these efforts. If emergency services provisions are triggered, a telephonic conference call should be held within 24 hours and an in-person debriefing meeting occur within 4 business days. Plan changes and revisions should be implemented immediately and revised plans be sent to all team members within one business day of the team meeting.

Cross-System Crisis Plan KY Example.pdf

A copy of cross system plan meeting minutes, the completed and signed plan, and staff notes related to all other direct and collateral contacts related to the coordination of the cross system crisis plan implementation and follow up should be maintained within the client record.

Transition/Termination of crisis services

Crisis services shall be terminated when the individual/guardian refuses services, if the individual is determined to not meet criteria for I/DD services as indicated in your CMHC eligibility policy and procedures, or when the crisis plan has been fully implemented without continuing crisis episodes. The client record should clearly indicate when services were ended and the reason for termination of services.

If an individual/guardian refuses services, the client record should clearly document when the refusal was provided as well as any reasons for the refusal. If the crisis consumer cannot be located or reached to provide services, then all efforts to contact the individual/guardian should be documented with specifics about the manner of attempted contact, number of attempted contacts, and response (voicemail left, mail returned, etc.)

If after completion of your agency's eligibility review process the individual is determined to not meet the criteria for I/DD services, the individual and their guardian should be notified of the reason why the individual does not qualify for services and referred to other appropriate resources to address their needs (such as behavioral health services, HCB waiver, etc.). All communication and referrals to other services should be clearly documented in the client record.

The CMHC crisis team should monitor the implementation of the crisis service plan. When all of the identified action items have been implemented and there have not been any additional crisis episodes, crisis services should end. Individuals with a cross system crisis plan may require intermittent monitoring and coordination to maintain the plan that would require continued crisis team involvement. The client record should clearly indicate how and when all t action items were implemented and the individual's current status at the time of termination of services. It should also be clear what types of ongoing services/supports (if any) the individual is receiving from other sources at the time of termination.